Proposal:
Illinois Medicare-Medicaid Alignment Initiative

The State is posting this proposal for a 30-day public comment period (February 17, 2012 through March 19, 2012) prior to submission to the Centers for Medicare and Medicaid Services (CMS) for consideration of approval. Please submit your comments by 5 P.M. on March 19, 2012 using the subject line "Dual Capitation Initiative" to the following email address: HFS.carecoord@illinois.gov.

To seek further input on the proposed demonstration, the State will hold additional stakeholder conferences. The first stakeholder videoconference will be held on February 23, 2012 at 1 P.M at 401 S. Clinton St, 7th Floor in Chicago, or 201 S. Grand Avenue East, 3rd floor in Springfield. See the care coordination website for dial-in information for the February 23, 2012 meeting and for the dates, times, and locations of future stakeholder meetings: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.

The State is particularly interested in receiving comments on defining adequate access to care, maintaining continuity of care as beneficiaries are transitioned into the demonstration, and beneficiary protections particularly related to self-direction and long-term services and supports.

1. Executive Summary

This draft proposal – to integrate care for individuals eligible for both Medicare and Medicaid under one managed care program – is one in a series of initiatives undertaken by the State of Illinois (State) through its Innovations Project.

The State's Innovations Project is in an effort to redesign the health care delivery system to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety and to implement IL Public Act 96-1501[1]. Due to the fragmented care dual eligible beneficiaries often receive – Medicare and Medicaid often work at cross purposes and impede care coordination – and the high cost of providing care to this population, the State is focusing efforts on improving care for dual eligible beneficiaries while reducing cost growth through its Innovations Project initiatives.

On a national level, dual eligible beneficiaries make up 25 percent and 46 percent of Medicare and Medicaid spending respectively. In contrast, dual eligible beneficiaries only constitute 16 percent and 18 percent of Medicare and Medicaid enrollment respectively.[2] In 2005, combined national average per capita spending totaled $26,185.[3] In Illinois, full dual eligible beneficiaries[4]

[1] IL Public Act 96-1501 requires at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the Department of Health Care and Family Services to be enrolled in a risk-based care coordination program by January 1, 2015.
[2] Medpac Report to the Congress: Aligning Incentives in Medicare. Chapter 5: Coordinating the care of dual eligible beneficiaries. June 2010, page 131.
[3] IBID
[4] Individuals eligible for Medicare and full Medicaid benefits.

make up 10.3% of Medicaid full benefit enrollment as of December 31, 2010 and 30.0% of Medicaid calendar year 2010 net claims-based costs.

The IL Medicare-Medicaid Alignment Initiative (demonstration) will integrate Medicare and Medicaid benefits and services to create a unified delivery system that is easier for beneficiaries to navigate. In addition, integrated financing streams will help to improve care delivery and coordination by eliminating conflicting incentives between Medicare and Medicaid that encourage cost shifting, reduce beneficiary access to high-quality care and community-based services, and result in a lack of care management for chronic conditions. The State and CMS will contract with managed care entities (Plans) that will be accountable for the care delivered to dual eligible beneficiaries including robust care coordination efforts where performance will be measured and payment will be tied to quality measurement goals. The demonstration will ensure access to all Medicare and Medicaid benefits and comprehensive services that address the Enrollees' full range of needs. The State is proposing to exclude the Adults with Developmental Disabilities home and community based (HCBS) waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with the Integrated Care Program (ICP). Care will be delivered in a team-based setting with integrated care coordination and care management services based on the needs and goals of Enrollees.

Enrollment in the demonstration will be voluntary – beneficiaries will have a choice of whether or not to enroll. Beneficiaries who choose to enroll in the demonstration will choose a medical home that will deliver care in a team-based environment with an emphasis on integrated primary and behavioral health services and coordinating care across providers. Enrollment will be supported by clear and accessible information – so that beneficiaries have all necessary information to make the choice to enroll – and facilitated by a neutral enrollment broker.

The State will ensure sufficient beneficiary protections including choice to enroll in the demonstration, choice of providers within the network, opportunities to maintain relationships with existing providers, and the ability to change or opt out of plans at any time. In addition, Plans will be required to implement meaningful consumer input processes in their ongoing operations and measure quality of service and care. The State will also maintain stakeholder meetings throughout the operation of the demonstration to ensure beneficiary satisfaction and quality of care.

With the release of this draft proposal, the State will describe its approach to developing and implementing a Medicare-Medicaid alignment model that will improve care for dual eligible beneficiaries, help the State achieve its goal to implement Public Act 96-1501 by January 1, 2015, and align with Affordable Care Act initiatives. The State proposes to enter into three-year contracts with managed care entities to provide the full array of benefits and supportive services (including pharmacy) afforded individuals under both Medicare and Medicaid[5]. The proposal uses the State's experiences implementing the Integrated Care Program (ICP) to develop a

[5] The State is proposing to exclude the Adults with Developmental Disabilities HCBS waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with the ICP.

managed care program that will improve the quality of care delivered to dual eligible beneficiaries.

Implemented in 2011, the ICP is a managed care program for Seniors and Adults with Disabilities (excluding dual eligible beneficiaries) in the IL counties of Cook, DuPage, Lake, Kankakee, Will and Kane, where local primary care physicians, specialists, hospitals, nursing homes, and other providers collaborate as a team to organize care around the needs of the beneficiary in order to achieve improvements in health. Highlights of ICP include:

- Better coordination of care, as members work with a team of providers to give them the best possible healthcare;
- Opportunity for beneficiary involvement in all healthcare decisions; and
- Additional programs and services to help them live a more independent and healthy life.

Overview: IL Medicare-Medicaid Alignment Initiative

The State is anticipating implementing a program similar to the ICP for dual eligible beneficiaries. This program will combine Medicare and Medicaid funding under a blended capitation payment to provide integrated, comprehensive care to full-benefit dual eligible beneficiaries ages 21 and over. The chosen Plans will be responsible for providing all medical, behavioral health, pharmacy, and long-term services and supports (LTSS) for Enrollees. The State is proposing to exclude the Adults with Developmental Disabilities HCBS waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with the ICP.

Plans must have networks that include providers that act as medical homes and coordinate high-quality, person-centered, planned care and are supported by care teams and the use of health information technology. The program will include unified requirements and administrative processes that – to the extent possible – accommodate both Medicare and Medicaid including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes. In addition, the program will include beneficiary protections such as:

- An ability to opt-out of the program at any time;
- On-going stakeholder input process at both the State and Plan levels;
- Choice of providers within Plan network; and
- Emphasis on continuity of care as beneficiaries are transitioned into the program.

The chart below provides a high-level overview of the proposal.

Target Population	Full benefit Medicare-Medicaid Enrollees ages 21 and over included in the AABD category of assistance and excluding the spend down population in the counties specified below

Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	278,000
Total Number of Beneficiaries Eligible for Demonstration	172,000
Geographic Service Area	Plans will propose to serve one or both of the following service areas: Greater Chicago: Cook, Lake, Kane, DuPage, Will, Kankakee Central Illinois: Knox, Peoria, Tazewell, McLean, Logan , DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion
Summary of Covered Benefits	All Medicare (Parts C and D) and Medicaid covered services including long-term care institutional and community-based services and supports. The State is proposing to exclude the Adults with Developmental Disabilities HCBS waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date.
Financing Model	Fully Capitated Contracts
Summary of Stakeholder Engagement/Input	Ongoing Efforts: Throughout the operation of the demonstration, Plans will be required to have quarterly consumer advisory board meetings and the State will have ongoing, quarterly stakeholder meetings through the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee, the Seniors and Persons with Disabilities (SPD) stakeholder group. These meetings will be available in alternative formats for individuals with disabilities. In addition, the State will contract with an outside entity to conduct an independent evaluation with consumer participation of the demonstration to ensure Plans are meeting the needs of Enrollees and to promote continuous quality improvement. The State will maintain an email box. For comments or concerns regarding the operation of the demonstration. please use the subject line "Dual Capitation Initiative" and the

	following email address: HFS.carecoord@illinois.gov. Summary of Efforts To-date: MAC Meeting 1/19/12; MAC Care Coordination Subcommittee 1/10/12; Long-term Care Medicaid Advisory Committee (MAC) 12/16/11; MAC 11/18/11; MAC Care Coordination Subcommittee Meeting 11/15/11; Kickoff Meeting Questions and Answers posted; Innovations Project Kickoff Meeting 10/13/11; Coordinated Care Key Policy Issues June 2011; and 13 SPD stakeholder meetings between April 2010 and December 2012.
Proposed Implementation Date(s)	January 1, 2013

Overall Vision/Goal

The State envisions a program that overcomes barriers to integration and improves upon and coordinates care for dual eligible beneficiaries who often have complex care needs and whose care is typically uncoordinated between Medicare and Medicaid or within either program. The following describes how the State's model overcomes the typical barriers to integration of Medicare and Medicaid to ultimately improve the care provided to dual eligible beneficiaries:

- Unified Administrative Processes: Currently, dual eligible beneficiaries have to navigate two programs with different yet overlapping benefits, differing eligibility and coverage rules, and separate sets of administrative processes and information notices to beneficiaries. Under the State's proposed model, the State and CMS will work to create unified administrative processes for beneficiaries including a seamless enrollment and disenrollment process for both programs and a single appeals process. Plans will provide a single Enrollee handbook that educates Enrollees on how to access Medicare and Medicaid services. At the same time, combined and unified administrative processes aim to reduce costs as both programs currently have to operate separate administrative processes for activities such as enrollment.

- Improved Care Coordination: Dual eligible beneficiaries often have multiple chronic conditions and/or disabilities that result in high program spending, but whose care is often uncoordinated across the two programs that provide necessary services. Lack of coordination across the two programs may often lead to unmet needs, underutilization of community-based services, and lack of care management for chronic conditions.

The State's proposal will improve upon the care delivered to dual eligible beneficiaries – who often have considerably varied care coordination needs – by establishing medical homes and person-centered care coordination requirements so that providers are aware of individuals acute and chronic medical, behavioral health, long-term care, and social service needs and the care they receive. The State's proposal will also increase access to appropriate and cost-effective services through improved utilization of community-based services, when appropriate, and integration of physical and behavioral health services. The demonstration will implement team-based care coordination and care planning that is based on individual need and directed by each Enrollee's needs, goals, and preferences.

- Integration of financing: The current misalignment of funding (separate payment and data collection for Medicare and Medicaid) and reliance on an inefficient fee-for-service (FFS) system further complicates the fragmented relationship between the two programs and exacerbates the effects of lack of care coordination. This financial misalignment may lead to the Medicare and Medicaid programs working in opposition and provides incentives to avoid costs rather than coordinate care. It can also lead to reliance on less appropriate and more costly hospital-based care and institutional LTSS. For example, in the past, States have not been able to share in savings to Medicare for increased Medicaid costs associated with transitioning more dual eligible beneficiaries to community-based care (typically a Medicaid covered service). In addition, States have historically not had access to Medicare data to fully understand dual eligible beneficiary utilization patterns and to implement robust care coordination programs. Integrated financing attempts to overcome these barriers and encourage coordinated care across the two programs.

  Under the State's proposal, Plans will receive a single capitation payment for all covered benefits to eliminate cost shifting incentives between the two programs. In addition, Plans receiving full payment will be linked to meeting annual quality measure targets as an incentive to study beneficiary utilization patterns and to implement the robust care coordination requirements proposed by the State.

Population

Within the selected geographic areas, the population that is eligible for the demonstration is full-benefit dual eligible beneficiaries – those that receive Medicare and full Medicaid benefits – up to 100 percent of the federal poverty level and ages 21 and over. The demonstration population includes individuals in the Aged, Blind and Disabled (AABD) category of assistance only and excludes the spend down population. Individuals enrolled in Home and Community Based (HCBS) waivers are eligible for enrollment in the demonstration. As of December 31, 2010, there were approximately 172,000 individuals in the demonstration population: 151,000 in the Greater Chicago region and 21,000 in the Central Illinois region (78% of the Greater Chicago region individuals reside in Cook county). 57.8 percent of the demonstration population is age 65 or older. The average Medicaid per member per month calendar year 2010 claims-based net costs for the demonstration population was $1,010 compared to $308 for all other full benefit Medicaid beneficiaries in Illinois. There was very little difference in costs between Greater Chicago and Central Illinois.

Of the demonstration population, 19 percent received care in an institutional setting and 22 percent received care in a HCBS setting, but contributed approximately 47 percent and 39 percent of total institutional care costs and HCBS costs among all full benefit Medicaid beneficiaries Statewide. Individuals with serious mental illness[6] (SMI) constitute 20 percent of the demonstration population and approximately 39 percent of this subpopulation received care in an institutional setting.

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	171,736	33,118	37,857
Age 65+	103,637	23,021	27,622
Under Age 65	68,099	10,097	10,235
Individuals with serious mental illness	33,722	13,160	5,301
Age 65+	11,922	7,074	3,128
Under Age 65	21,800	6,086	2,173

Among dual eligible beneficiaries, care coordination needs vary greatly depending upon considerations such as age, health status, whether an individual has a physical or intellectual disability, the incidence and variety of chronic conditions, and whether the individual receives care in an institutional or community setting. As such, the State proposes to implement a demonstration that is sensitive to individual health needs and goals in order to promote person-centered care coordination and planning.

2. Care Model Overview

Proposed Delivery System

Through the implementation of the demonstration, the State expects to improve the quality of care delivered to dual eligible beneficiaries through improved coordination of Medicare and Medicaid covered services and implementation of a medical home and care planning requirements that support individual beneficiary needs. The State plans to solicit proposals and to contract with Plans that will be responsible for the delivery of all covered Medicare and

[6] Serious Mental Illness (SMI): For purposes of these statistics, the State used the following diagnoses schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51).

Medicaid benefits and for the provision of extensive care coordination activities. The State is proposing to exclude the Adults with Developmental Disabilities HCBS waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with ICP.

The State proposes to operate the demonstration in two service areas. The Greater Chicago service area will include the following counties: Cook, Lake, Kane, DuPage, Will, and Kankakee. The Central Illinois service area includes the following counties: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, and Vermilion. The State selected these regions because of the density of the dual eligible population and the existence of a robust medical infrastructure and choice of providers. The State feels that these factors will contribute to the success of this model and allow two completing Plans to be viable. Plans may choose to serve one or both of the defined service areas. Plans must offer to serve the entire defined service area(s) it chooses. During year two of the demonstration, the State is considering expanding into other geographic areas and seeks input on other possible geographic areas that could benefit from the demonstration. In these service areas, the State will seek proposals from Plans that implement and provide assurances that the Plan can manage the demonstration requirements. (The term Plan is used in this proposal to mean managed care organization (MCO)).

Under the proposed demonstration, care delivery will be anchored in a medical home and supported by care teams that are tailored and personalized to meet individual care needs and focused on providing a multidisciplinary approach to care delivery, care coordination, and care management for those with complex needs. Plans will be required to assure the integration of physical and behavioral health services. In addition, Plans will be required to develop and maintain networks that assure access to all necessary services and to maintain relationships with community-based organizations to focus on and ensure independence for individuals with disabilities. See *Proposed Benefit Design* for more detail.

- Enrollment: This is a voluntary demonstration and Enrollees will have the choice of whether or not to participate. The State will implement a unified, passive enrollment process that provides beneficiaries the opportunity to enroll or disenroll from a Plan at any time. Beneficiaries will be provided a choice to enroll and will have the opportunity to choose from at least two Plans in a geographic area or to remain in fee-for-service (FFS). If a beneficiary does not exercise an affirmative choice, they will be auto-assigned to a Plan. Future auto-assignment will be set so that higher performing Plans (according to variables such as quality measurement and consumer satisfaction) are preferred. Poor performing plans will be at risk of suspension of new enrollment. Enrollees will not be locked-in to Plans and will be able to disenroll or transfer Plans on a month-to-month basis at any time during the year. Additionally, Enrollees will not be locked-in to PCPs. Requests to change PCPs will occur within 30 days. The State will work with the federal Centers for Medicare and Medicaid Services (CMS) to develop a single unified enrollment process.

  In order to support enrollment decisions, the State will ensure that beneficiaries are educated on Plan benefits and networks, the processes for opting out of the demonstration or changing PCPs, and the unified grievance and appeals processes. The State will focus on developing

clear and accessible information (ensuring availability in alternative formats and languages) on available Plans and beneficiary protections (including whether members' doctors and providers are in Plan networks and the benefits available through Plans). The State understands that beneficiaries may be hesitant to embrace managed care and will work with stakeholders to alleviate concerns and ensure that they have enough information to make an informed choice about enrollment. In order to help facilitate enrollment choices, the State will contract with a neutral enrollment broker to help deliver Plan information and to conduct outreach and education sessions for potential enrollees. To ensure that enrollment information is available and accessible to all potential Enrollees, the State will ensure that auxiliary aids and services are available.

- Provider Networks: Plans will be required to establish and maintain a network of providers – either directly or through subcontractual arrangements – that assures access to all Medicaid and Medicare benefits. The networks must include a broad array of providers including PCPs, specialists, behavioral health providers, ancillary providers, hospitals, pharmacists, and providers of LTSS, home care, and other community supports. The right of Enrollees to select their own personal assistance will be preserved and protected. The State plans to ask for a detailed description of Plan networks in the proposal and evaluate each proposal thoroughly to assure adequate access including variety of available providers, after hours availability, geographic location of providers, distance, travel times, and physical accessibility for those with disabilities. In addition, Plans will be required to co-locate physical and behavioral health and will be asked to describe their approach to co-location in the RFP. For selected health plans, the approach described in the proposal will be negotiated with CMS and the State and will become a contractual requirement.

  Learning from our experience in the ICP, the State plans to ensure network adequacy before implementation. In addition, the State expects that Plans will be able to build adequate networks more quickly under the demonstration because Medicaid providers are acknowledging the movement to managed care in IL and some potential Plans will have experience and established networks with Medicare.

  Plans will be limited to a number of Enrollees that does not exceed their capacity to provide the full continuum of Medicare and Medicaid benefits covered under the demonstration. Plans must be licensed according to State licensure and solvency requirements. Plans must credential providers in accordance with National Committee for Quality Assurance (NCQA) standards, when applicable, and IL standards, otherwise, and must recredential every three years. Furthermore, Plans providing services under the demonstration must be NCQA accredited within three years of the demonstration effective date.

  In addition, Plans will be required to conduct outreach to beneficiaries' current providers and propose mechanisms for encouraging these providers to enroll in its network to ensure continuity of care; ensure providers in its network will accept new beneficiaries; and ensure network providers are multi-lingual and culturally relevant for the community it proposes to serve. In order to ensure network adequacy, the State will provide files to interested Plans of providers currently used by dual eligible beneficiaries in the demonstration areas. Plans will be asked to demonstrate how its network consists of providers with experience serving

various disability types and to describe its relationships with community organizations that focus on recovery and independence for those with disabilities.

- Network Adequacy / Access to Care: Plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. In addition the following requirements will be imposed:
  - Plans will be limited to a maximum primary care physician (PCP) to Enrollee ratio of 1:600;
  - Plans will be required to analyze network adequacy on a quarterly basis and immediately identify gaps and develop recruitment strategies as necessary. Plans will be required to have contingency plans in case of network inadequacy, a provider contract termination, or insolvency;
  - PCPs and specialty providers must have a published after-hours telephone number to ensure access to care; and
  - Plans will work with providers to comply with the American Disabilities Act (ADA) and to demonstrate the capacity to deliver services in a manner that accommodates special needs.

- Outreach and Marketing: The State will develop unified marketing and outreach rules that include both Medicaid and Medicare requirements as appropriate. All Plan marketing materials will require CMS and State prior approval. To ensure effective communication, written documents must be at sixth grade reading level and Plans must offer translated materials and alternative methods of communication such as Braille. The State will contract with a neutral enrollment broker to increase awareness about the demonstration and to inform enrollment choices through avenues such as mailings or print and virtual media and through outreach and education sessions for Potential Enrollees.

- Grievances and Appeals Process: The State will develop a unified grievance and appeals process. The appeals process will include an exhaustion of the Plan's internal appeals process prior to review by the Medicare-qualified external independent contractor.
  - Internal appeals processes will be governed by a unified set of requirements for Plans that incorporate relevant Medicare Advantage, Part D, and Medicaid managed care requirements; and
  - The State will develop one document describing this unified process.

- Quality Measurement: The State will use quality measures from both Medicaid (ICP) and Medicare to assess Plan performance. See Attachment A for a list of proposed quality measures. The State will work with CMS to jointly determine the measures to be used as pay-for-performance. See *Financing and Payment* for more details on pay-for-performance. The State will develop a single, comprehensive quality management and consolidated reporting process. We will work with CMS and IL stakeholders to explore additional measures of community integration and beneficiary empowerment.

- Performance Improvement: The State along with CMS will require the development of an ongoing quality improvement program including performance improvement projects.

Proposed Benefit Design

Following the example of Illinois' Integrated Care Program for non-Medicare eligible Seniors and Persons with Disabilities on Medicaid, the program will make selected MCOs responsible for providing or arranging to provide all Medicare services in accordance with 42 C.F.R. 422.101 (including inpatient, outpatient, hospice, home health, and pharmacy) and all Medicaid services including behavioral health, long-term institutional and community based long term supports. The State is proposing to exclude the Adults with Developmental Disabilities HCBS waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with the ICP. (See Attachment B for a list of Medicaid State Plan services available under the demonstration and Attachment C for the HCBS waiver services included in the demonstration). Plans may propose to offer supplemental benefits that exceed those currently provided in either Medicare or Medicaid as long as they are provided under the blended Medicare and Medicaid capitation rate. In addition, Plans will be responsible for coordinating referrals for other non-covered services, such as supportive housing and other social services to maximize opportunities for independence in the community.

The RFP will seek Plans that are capable of operating a care coordination model that is anchored in a medical home, tailored to individual need and takes into account whether an individual has a physical or intellectual disability, and supported by multidisciplinary care teams. Plans will be required to implement care models that are built on Enrollee's needs and preferences and delivered in a cultural and linguistically appropriate environment.

- Medical Homes: Plans must operate networks – from which Enrollees will choose a medical home – that include providers that act as medical homes with a focus on Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), PCP-centered medical groups, and private practice PCP offices. Medical homes will provide evidence-based primary care services, family-centered health promotion, wellness programs, acute illness care, and chronic health condition management. Medical homes – supported by multi-disciplinary care teams and health information technology – will coordinate care across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care and coordination between physical and behavioral health. As part of a care team, medical homes will engage in discharge planning, medication management, assuring integration of specialty care, and referrals for behavioral health and community-based resources. The Plans will be required to have a process in place to facilitate medical homes advancing towards NCQA certification.

- Care Coordination: Plans will be required to provide care coordination services that ensure effective linkages and coordination between the medical home and other providers and services, monitor transitions between levels of care, facilitate discharge planning, and provide care management for those identified to have complex needs. Plans will be required to coordinate with HCBS case managers during transition and, where applicable, may contract with HCBS case managers to provide waiver services. Effective care coordination will include the following components:

- Information Technology: The State will seek Plans that have technology in place to assist with care coordination that includes a clinical information system to be used to track care delivered outside the medical home (with Enrollee consent). The State will seek Plans that will operate a secure web-based application for Enrollees and providers. The State desires that the web-based Enrollee portal provide information about the Plans and include Enrollee health history and care plans. The web-based secure application for providers should include care plans, claims information, demographics, and lab results and allows for entry by providers at the point of service. The information technology will be used by medical homes, the multidisciplinary care team, and other providers to monitor:

    - Provider/Enrollee communication;
    - Enrollee profiles including demographics, claims payment information, goals, care plan adherence, care gap alerts, lab results, etc.; and
    - Inbound and outbound Enrollee contact.

    Plans shall ensure the privacy of Enrollee health records and provide for access to such records by Enrollees.

- Health Risk and Behavioral Health Screening and Assessment: Plans must use best efforts to ensure completion of health risk and behavioral health screenings within 90 days after enrollment and complete assessments, identify needs for care management, and develop Enrollee care plans within 120 days after enrollment.

- Care Management: For those identified through the health risk and behavioral health screening as needing care management, a multi-disciplinary care team will work with the Enrollee to develop a care plan and provide care management services. The goals of care management are to ensure the delivery of high quality care; improve health status; enhance coordination across the spectrum of the health care system with particular emphasis on transitions between levels of care; reduce avoidable hospitalizations; and identify opportunities that support recovery and independence in the community.

    - Multi-disciplinary Care teams: Multi-disciplinary care teams will support medical homes and provide care management for those identified through the health risk and behavioral health assessments as medium or high risk. Teams may include (as appropriate to individual need) an assigned care coordinator, behavioral health professional, the PCP, a community liaison, pharmacist, and specialist. The Enrollee will be provided the opportunity to be an active participant in their care team.

    Care coordinators will lead these multidisciplinary teams and will have prescribed caseload limits that vary based on risk-level. The care coordinator will work with the Enrollee and the multi-disciplinary team to develop and maintain the Enrollee's care plan, to coordinate and maintain critical information sharing among the care team and Enrollee, and to ensure that Enrollees are meaningfully

informed about their care options. Plans will ensure that care coordinators are culturally competent and have the training to work with and address the diverse needs of the demonstration population.

Plans must ensure that Enrollees have adequate access to his or her team through methods such as regularly scheduled appointments including face-to-face visits and email and telephone options.

- Multi-disciplinary Team Responsibilities include:
    - Supporting the medical home to coordinate care across the spectrum of the health care system including managing transitions between levels of care;
    - Conducting health risk and behavioral health assessments;
    - Developing care plans based on Enrollee goals;
    - Monitoring care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the PCP – to ensure timely transmission of information;
    - Medication reviews;
    - Self-management training;
    - Enrollee health education;
    - Assuring integration of the following services across settings and with the medical home:
        - Specialty care
        - Medication management
        - Institutional care
        - Inpatient
        - Emergency room; and
    - Identifying available community-based resources and monitoring use of day-to-day of community-based services.

- Care Plans: Plans will be required to work with the beneficiary and his or her family and/or caregiver to develop a single comprehensive person-centered Enrollee care plan for each Enrollee stratified through the health risk or behavioral health screening as medium or high-risk or for those Enrollees otherwise identified as needing a care plan. The care plan must incorporate strategies and identifiable goals to address the Enrollee's needs and preferences. Plans shall use the Enrollee care plan to facilitate monitoring of an Enrollee's progress toward their goals, and evolving service needs.

  The Enrollee, their PCP, other providers, a legal representative, family and/or caregiver shall be provided the opportunity to collaborate on the development and implementation of the Enrollee care plan. Each Enrollee will be given the opportunity to confirm agreement with the Enrollee care plan.

    - Elements of Care Plan: Based on the needs and preferences as identified through the health risk or behavioral health assessment, the care plans should include:

- Summary of Enrollee's health history;
- Enrollee's goals;
- Actions, including interventions to be implemented;
- Progress noting Enrollee's success;
- Barriers or obstacles;
- Timeframes for completing actions;
- Status of Enrollee's goals;
- Crisis plans for an Enrollee with Behavioral Health conditions;
- Determine need for community resources and non-covered services; and
- Include negotiated risk identification and documentation.

o Hospitalist and SNFist programs: Plans will be required to operate hospitalist and SNFist programs. The State will require that Plans have a hospitalist program designed to minimize admissions and length of stay and to ensure adequate discharge planning. Plans will be required to have an adequate network of providers specializing in care for nursing facilities – a SNFist program – to care for the population residing in nursing homes. The SNFist program must include visiting onsite care by the SNFist in the nursing home.

o Other Requirements: In addition to providing the care coordination services outlined above, Plans will be required to assure beneficiary access to quality care including:

- Telephone Access: Plans will be required to employ customer service representatives that are culturally competent and sensitive to the population served and to operate a toll-free number for benefits and eligibility information and to file grievances. Plans will also be required to operate 24-hour telephone access for confirmation of eligibility and prior approvals and a Nurse Advice line.

- Engagement of Enrollees: Plans will use a multifaceted approach to locate and engage Enrollees and shall capitalize on every Enrollee contact to engage the Enrollee in their own care. For example, Plans will implement a telephonic outreach program to educate and assist Enrollees in accessing services and managing their own care. Calls will be made by Plan staff, or by the nurse advice line, to new Enrollees and to targeted populations such as Enrollees who are identified or enrolled in care management, who have frequent emergency room utilization or who are due or past due for services.

- Enrollee Health Education: Plans must offer health education programs that use comprehensive outreach and communication methods to effectively educate Enrollees, their families or caregivers about health conditions and self-care and how to access plan benefits and supports. Plans may offer Enrollee incentive programs to promote personal health responsibility and ownership. The incentives offered by the Plan to eligible Enrollees may include rewards for completing annual preventive health visits; attending a follow-up visit within

seven (7) days after discharge of an admission for Mental Illness; and completing other recommended preventive health and chronic health condition screenings.

- Additional Benefits or ancillary/supportive services: Plans will be asked to propose additional benefits – within the blended capitation rate – that will help Enrollees stay in or move to the community.

Evidence-based Practices

The State expects Plans to apply well-established evidence-based clinical guidelines promulgated by leading academic and national clinical organizations. Plans will be required to have processes for educating providers on employing evidence-based guidelines and for monitoring providers' use of evidence-based practices. Plans shall adopt clinical guidelines for chronic conditions including asthma; coronary artery disease; diabetes; behavioral health screening, assessment, and treatment including medication management and PCP follow up; and clinical pharmacy medication review.

In the RFP, Plans will be asked to specify evidence-based practice guidelines it expects to employ that are relevant to the demonstration. Examples include the Coleman or Naylor care transition models, Assertive Case Treatment, and Integrated Dual Diagnosis Treatment.

Context within Current State Initiatives

This program is one in a series of the State's initiatives to transform the health care environment in Illinois to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety. Within the Innovations Project, the State is focusing on improving the care provided to those with complex needs including dual eligible beneficiaries. The State recently released a solicitation requesting proposals for Care Coordination Entities (CCE)[7] / Managed Care Community Networks (MCCN)[8] where hospitals, physician groups, Federally Qualified Health Centers (FQHC) or social service organizations would form legal entities to coordinate care across the spectrum of the healthcare system for Seniors and Adults with Disabilities including those dually eligible for Medicare and Medicaid. Their efforts are required to have a particular emphasis on managing transitions between levels of care and coordination between physical and mental health. Full payment is based on meeting specific quality indicators. This spring, the State will implement a similar proposal for children with complex medical needs

Further, implementation of a managed care program for dual eligible beneficiaries helps the State implement the Medicaid reform law of moving 50 percent of beneficiaries from fee-for-service (FFS) to risk-based care coordination by January 1, 2015. In addition, implementation of the demonstration builds upon a recent State initiative to improve care for Seniors and Adults with Disabilities, the Integrated Care Program (ICP). ICP is the State's managed care program for Seniors and Adults with Disabilities who are not eligible for Medicare, through which Enrollees

[7] CCEs will receive an enhanced administrative fee to coordinate care in a fee-for-service system.
[8] MCCNs will receive a capitation rate because – in addition to fulfilling the care coordination requirements required by the solicitation – the entities will bear risk for all services covered in its contract with the State.

receive all covered Medicaid services including acute, behavioral health, and long-term care services and supports through managed care. This program, which includes robust care coordination efforts, established a foundation for the development of the IL Medicare-Medicaid Alignment Initiative.

This proposal also fits within expected state plan activity and alignment with Affordable Care Act (ACA) initiatives. The State is planning to submit a SPA to implement the health home option offered through Section 2703 of the ACA, which would fit within this proposed demonstration as far as Plans will be required to manage the care of dual eligible beneficiaries with chronic conditions through the use of a health home.

In addition, the State operates nine Home and Community-Based Services (HCBS) waivers, which allow Medicaid enrollees to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting. Each HCBS waiver is designed for individuals with similar needs and offers a different set of services. All HCBS waivers will be renewed in calendar year 2012. Plans will be required to coordinate with HCBS case managers during transition and, where applicable, may contract with HCBS case managers to provide waiver services. Four of the nine HCBS waivers the State operates are included in the demonstration. The State is proposing to exclude the Adults with Developmental Disabilities home and community based (HCBS) waiver services from the demonstration at this time. The State is exploring with CMS the option to phase-in these services at a later date in order to assure extended stakeholder input and consistency with the Integrated Care Program (ICP). More information on these can be found in Attachment B (Medicaid Covered Services) and at the following link: http://www.hfs.illinois.gov/hcbswaivers/.

3. Stakeholder Engagement and Beneficiary Protections

Engagement of Stakeholders During Planning Process

The State began stakeholder engagement in the planning of managed care programs for the disabled and elderly populations in April 2010. Since then, the State held 13 planning meetings specific to managed care development and engaged stakeholders in topics pertinent to the development of a managed care program including consumer direction, quality outcomes and measurement, care management coordination, enrollment, and provider networks. The State maintains an active stakeholder group whose feedback is relevant to the development of the demonstration. Examples of stakeholder feedback and lessons learned that informed the development of the proposed demonstration include to ensure network adequacy before implementation of the demonstration; to require Plans to work with providers to meet ADA compliance; and to ensure continuity of care as beneficiaries are transitioned into the program.

The State intends to continue stakeholder engagement with additional meetings during the 30-day posting period. The State will specifically engage stakeholders on aspects important to Medicare-Medicaid alignment including enrollment methods and network adequacy.

Furthermore, the State actively engaged stakeholders in the Innovations Project planning process of which the demonstration is a component. In June, the State released its *Coordinated Care Key*

Policy Issues document through which it solicited stakeholder feedback on developing coordinated care programs. The State received 75 responses to its *Coordinated Care Key Policy Issues* document, which it used to inform the development of the Innovations Project initiatives, which includes improved care delivery for dual eligible beneficiaries.

After the State developed its framework for the Innovations Project initiatives, it hosted a kick-off meeting in October 2011 that was also available via webinar. The kick-off meeting had over 1,000 participants / webinar subscribers. Based on the information provided during the kick-off meeting, the State received over 100 questions and provided written responses to questions via its website.

In addition, the State holds stakeholder meetings at least quarterly through the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee meetings, and the SPD stakeholder group. The State provides updates on the planning and implementation of the Innovations Project initiatives including the proposed demonstration and continues to receive stakeholder feedback on its efforts through the stakeholder meetings and other avenues, including the care coordination website which includes a comment function.

Below is a list of methods the State used to engage stakeholder feedback including stakeholder meetings to date and the release of the *Coordinated Care Key Policy Issues* document.

Stakeholder Involvement To-Date

- Medicaid Advisory Committee (MAC) – 1/19/12;
- MAC Care Coordination Subcommittee – 1/10/12;
- Long-term Care Medicaid Advisory Committee (MAC) – 12/16/11;
- MAC – 11/18/11;
- MAC Care Coordination Subcommittee – 11/15/11;
- Responses to Webinar Questions and Answers;
- Innovations Project Kickoff (Webinar) – 10/31/11;
- Coordinated Care Key Policy Issues – June 2011; and
- 13 SPD stakeholder meetings between April 2010 and December 2012.

Ongoing Stakeholder Engagement

To seek further input on the proposed demonstration, the State will hold additional stakeholder conferences. The first stakeholder videoconference will be held on February 23, 2012 at 1 P.M at 401 S. Clinton St, 7th Floor in Chicago, or 201 S. Grand Avenue East, 3rd floor in Springfield. See the care coordination website for dial-in information for the February 23, 2012 meeting and for the dates, times, and locations of future stakeholder meetings: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.

The State plans to continue active stakeholder involvement in the development, implementation, and operation of the demonstration. The State welcomes ongoing feedback related to the demonstration and has an email address dedicated to receiving comments on an ongoing basis.

All comments, questions, or concerns can be emailed using subject line "Dual Capitation Initiative" to the following email address: HFS.carecoord@illinois.gov.

In addition to the stakeholder meeting and dedicated email address, the States proposes additional methods for continuing stakeholder involvement throughout the operation of the demonstration:

- Plans will be required to have quarterly consumer advisory board meetings;
- The State will have ongoing, quarterly stakeholder meetings to continue to receive input on the operations and success of the program including through the MAC and the MAC Care Coordination Subcommittee, and the SPD stakeholder group. The State will use this feedback as a means for determining program and contract improvements; and
- The State will make stakeholder meetings available in alternative formats for individuals with disabilities, when requested.

Description of Beneficiary Protections

The State carefully designed the demonstration to ensure adequate beneficiary protection through various methods. In addition, the State invites feedback on ways to continue to improve beneficiary protections under the proposed demonstration. Below highlights the protections that the State plans to include in the demonstration:

- Adequate Networks: Plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. Where there is overlap in services covered between Medicare and Medicaid, the State and CMS will negotiate and determine the appropriate network adequacy requirements. In addition, Enrollees will have a choice of providers from a broad network of providers including PCPs, behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and providers of LTSS, home care and other community supports.

- Continuity of Care: The program will emphasize continuity of care as Enrollees are transitioned into it. The protections will go beyond the requirements for transition of care in Illinois' Managed Care Reform and Patient's Rights Act (215 ILCS 134/25, which can be found at http://www.ilga.gov/legislation/ilcs/documents/021501340K25.htm). Below lists some of the proposed continuity of care protections for Enrollees:

  - In addition to a 180-day period in which Enrollees may maintain a current course of treatment with an out-of-network provider, they will be able to maintain existing PCP arrangements for 180 days and all current providers will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network;

  - All prior approvals for drugs, therapies or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 90 days post enrollment and will

not be terminated at the end of 90 days without advance notice to the Enrollee and transition to other services if needed;

- Plans shall assume responsibility for an Enrollee receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment; and

- Plans shall assume full responsibility for pre-existing conditions upon effective date of enrollment.

- Self-directed care: The right of Enrollees to select their own personal assistance will be preserved and protected. Plans will be contractually required to provide assurances of consumer-direction throughout their care plans and service delivery model. Personal assistance will be guaranteed a fair wage.

- Enrollee Rights: Plans must ensure the Enrollee right to:

  - Be treated with respect and consideration for their dignity and privacy;
  - Receive information on available treatment options and alternatives, presented in a manner appropriate to the their condition and ability to understand;
  - Participate in decisions regarding their health care, including the right to refuse treatment;
  - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
  - Request and receive a copy of their medical records, and to request that they be amended or corrected; and
  - Exercise their rights, and that the exercise of those rights will not adversely affect the way they are treated.

- Grievance and Appeals Processes: The State will develop a unified grievance and appeals process. The appeals process will include an exhaustion of the Plan's internal appeals process prior to review by the Medicare-qualified external independent contractor.

- Communication: Plans will be required to meet the following requirements for all communications with Enrollees including but not limited to marketing and outreach materials, basic health plan information, Enrollee health education campaigns, and telephone access and shall meet the following requirements:

  - Written documents shall be at a sixth grade reading level;
  - Plans will offer alternative methods of communication (Braille, sign language, etc.) as well as translated materials; and
  - All Enrollee material shall require CMS and State approval prior to use.

4. Financing and Payment

Financial Alignment Model

The program will use a full-risk capitation model for the full range of Medicare and Medicaid (both state plan and HCBS waiver) services. Rate cells will be designed to incent plans to provide services in the least restrictive setting. The State will make monthly payments to Plans for the Medicaid portion of the capitation rate. CMS will make monthly payments to Plans for the Medicare portion of the capitation rate including Part D.

Rates for participating Plans will be developed by the State in partnership with CMS based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans.

Incentive Payment Plan

The State proposes to implement a pay-for-performance structure similar to that in the ICP. The State will withhold a specified percentage from capitated payments on a monthly basis, which Plans will be eligible to receive as an incentive payment for meeting specific quality measure targets. Plans will be required to meet quality measure targets annually in addition to a minimum performance standard to earn incentive payments. Each measure will have an equal share of the incentive payment associated with it.

Below lists the total amounts proposed to be withheld per demonstration year:

- Year One: 1%
- Year Two: 1.5%
- Year Three: 2%

Quality Measures

In order to compare performance across State initiatives for similar populations, the State plans to measure Plan performance using at a minimum the ICP quality measures. See Attachment A for a list of the ICP quality measures. The State will work with CMS to add to this list of measures to reflect quality measures appropriate to the population and to meet other federal requirements, as necessary.

In addition, the State will work with CMS to identify quality measures that will be used as pay-for-performance and expects the identified measures will include at least some of the measures included in Attachment A. The State will also work with CMS to identify quality measure baselines and annual targets. This information will be included in the RFP.

Payments to Providers

Plans will be asked to propose creative payment plans that encourage a holistic approach to beneficiaries, quality outcomes and evidence-based practice. Plans will be encouraged to propose payment structures for medical homes that include a balanced combination of capitation, fee-for-service and pay-for-performance to encourage care coordination, preventive care and maintenance of chronic conditions, such as bundled payments for episodic specialty care. Safeguards will be in place to ensure full encounter data is received from any capitated entity.

5. Expected Outcomes

State ability to monitor, collect and track data on quality and cost outcome metrics

The Department of Healthcare and Family Services (HFS) has a knowledgeable staff within the Bureau of Managed Care with many years experience monitoring and tracking Medicaid quality and cost data including with the ICP and the State's voluntary managed care programs. HFS will build upon this experience and infrastructure to develop a quality and cost measurement program and strategy for the Medicare-Medicaid Alignment Initiative. The State is hiring additional personnel in quality, encounter data collection, and data analytics to provide additional capacity to monitor, collect, and track data on quality and cost outcomes in the proposed demonstration. The State has a state-of-the-art data warehouse and is adding analytical tools to allow the State to more fully analyze and track data related to the proposed demonstration.

On an operational level, the ICP quality measures are already programmed in State's data warehouse, which will help to create a smooth transition when implementing the Medicare-Medicaid Alignment Initiative quality program. Furthermore, the State will require Plans collect and report encounter data using a uniform encounter reporting method to be developed by the State and CMS.

- Reporting Measures: As discussed in *Financing and Payment*, the State will use quality measures from both Medicaid (the State's ICP) and Medicare to assess Plan performance. See Attachment A for an initial list of proposed measures. The State will jointly develop with CMS a single, comprehensive quality management and consolidated reporting process. Furthermore, the State and CMS will jointly determine quality measure targets.
- Performance Improvement: The State along with CMS will require the development of an ongoing quality improvement program including performance improvement projects.

Expected impact of the proposed demonstration on Medicare and Medicaid costs

The State expects an integrated program to result in improved quality of care for dual eligible beneficiaries. Through improved care coordination and reduced cost shifting incentives between Medicare and Medicaid, the State's goal is to ensure access to all Medicare and Medicaid benefits and comprehensive services that address the Enrollees' full range of needs and improve utilization of appropriate and cost-effective services including community-based services. As such, the State expects:

- An increase in the number of beneficiaries participating in and receiving care coordination;
- An increase in the number of health risk and behavioral health screenings;
- An increase in the number of beneficiaries with care plans;
- Improved access to HCBS waiver and other supportive services;
- Reduced hospital readmissions, inappropriate ER utilization, and non-emergency transportation costs particularly for nursing home residents; and
- Improved beneficiary satisfaction.

According to a 2011 CMS report, Illinois is among the highest – sixth highest – in potentially avoidable hospital readmission rates among dual eligible beneficiaries nationally.[9] Additionally, according to CMS, Illinois is among the highest in institutional payments and lowest in HCBS spending as a percentage of all long-term care spending.[10] Using federal fiscal year (FFY) 2009 data, the CMS analysis indicates that Illinois had the eighth highest level of institutional payments nationally and the third lowest rate nationally of HCBS spending as a percentage of all long-term care spending in the State.[11] While this information is not specific to dual eligible beneficiaries, full dual eligible beneficiaries account for approximately 68 among percent of all long-term care (institutional and HCBS) spending in IL Medicaid. Furthermore, according to State estimates, the full dual eligible beneficiaries accounted for approximately 47 percent of all nonemergency medical transportation costs in the State in 2010. These statistics indicate that there is need in IL to improve care delivery for dual eligible beneficiaries and to shift long-term care utilization from institutions to the community, as appropriate.

The federal government contracted with Mercer to perform an analysis of the demonstration and to provide detailed financial Medicare and Medicaid projections over the next three years, including estimates of how much savings are anticipated. Therefore, detailed financial projections and further analysis of cost savings will be provided at a later date.

6. Infrastructure and Implementation

State Infrastructure/Capacity

HFS has a knowledgeable staff within the Bureau of Managed Care with many years experience monitoring the State's voluntary managed care programs and the ICP. Furthermore, in the last several years, the State implemented a Primary Care Case Management program (PCCM), disease management, and managed care (ICP) program. In addition, the State is hiring personnel in managed care administration including expertise in Medicare to provide additional capacity to monitor contract compliance and otherwise implement the proposed demonstration.

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[9] Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations.
http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf
[10] Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement.
http://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf
[11] IBID

Expected Use of Contractors

The State will use an External Quality Review Organization (EQRO) to complete readiness reviews, compliance reviews, validate performance measures, validate performance improvement projects, and provide technical assistance as needed. The State is in the process of procuring a new EQRO and the State will include the responsibilities associated with the demonstration in the RFP.

In addition, the Department expects to contract with an outside entity to conduct an independent evaluation of the demonstration similar to that performed by the University of Illinois at Chicago (UIC) for the ICP.

Overall Implementation Strategy and Anticipated Timeline:

Timeframe	Key Activities/Milestones	Responsible Parties
Feb 17 – Mar 19	State posts proposal for 30 days	IL
Mar 26 – Apr 24	CMS posts proposal for 30 days	CMS
Apr 30	RFP Release	IL / CMS
Apr 30	SPA (to implement voluntary Medicaid managed care for dual eligible beneficiaries) submitted to CMS	IL
Jun 15	Proposals Due	Plans
July 30	SPA approved	CMS
July 31	Plan selections announced	IL / CMS
July – Sept	Readiness Reviews	IL / CMS
Aug 1	Hiring program staff complete	IL
Sept 20	Contracts signed	IL / CMS / Plans
Oct 1	Enrollment materials sent to beneficiaries	Plans / Enrollment Broker
Oct 15 – Dec 7	Open Enrollment	Plans
Oct 15 – Nov 15	System Changes complete / Testing begins	IL
Jan 1, 2013	Enrollment effective date	

Jan, 2013 and beyond	Contract monitoring and compliance Stakeholder feedback	IL / CMS / Plans

7. Feasibility and Sustainability

Potential barriers/challenges and/or future State actions

None anticipated.

Statutory and/or regulatory changes needed

None needed.

New State funding commitments or contracting processes necessary

None needed.

Scalability of the proposed model and its replicability in other settings/States

The State will test the demonstration in the geographic areas chosen through the RFP process and hopes to determine replicability in other areas of the State through evaluation of program success (e.g. achievement of quality measures goals; cost measurement). To assist in these efforts, the Department expects to contract with an outside entity to conduct an independent evaluation of the demonstration similar to that performed by the University of Illinois at Chicago (UIC) for the ICP.

8. Additional Documentation (as applicable)

List of State Plan Amendments

The State anticipates submitting the following State Plan Amendments:

- To allow dual eligible beneficiaries into voluntary Medicaid managed care; and
- Health Homes.

Attachment A
Quality Measures

#	Category	Quality Measure	Specification Source
1	**Behavioral Health Risk Assessment and Follow-up**	New Enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment	
	1) Behavioral Screening/ Assessment within 60 days of enrollment		State
	2) Behavior Health follow-up within 30 days of screening		State
2	**Alcohol and other Drug Dependence Treatment**	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®
3	**Behavioral Health Support**	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis.	State
4	**Behavioral Health Support**	Follow-up after hospitalization for Mental Illness	
	1) Follow-up in 7 days		HEDIS®
	2) Follow-up in 30 days		HEDIS®
5	**Care Coordination Influenza Immunization Rate**	Enrollees who received at least one influenza immunization annually.	State
6	**Dental Utilization**	Enrollees who receive an annual dental visit	
	1) Annual Dental Visit –All		State
	2) Annual Dental Visit – DD only		State
7	**Dental ER Utilization**	Emergency room visits for Enrollees with dental primary diagnoses.	State
8	**Diabetes Care**	Increased utilization of disease specific therapies. Meet two of numbers 1, 2, and 3 and one of numbers 4 and 5.	
	1) HbA1c testing 1x per year		HEDIS®

#	Category	Quality Measure	Specification Source
	2) Microalbuminuria testing 1 X per year		HEDIS®
	3) Cholesterol testing 1X per year		HEDIS®
	4) Statin Therapy 80% of the time		State
	5) ACE/ARB 80% of the time		State
	6) DD Waiver Program Support	Services for Enrollees in DD Waiver and Enrollees with DD Diagnostic History - HbA1c testing 1x per year	HEDIS®
9	**Congestive Heart Failure**	Increased utilization of disease specific therapies (meet 2 of 3).	
	1) ACE/ARB 80% of the time		State
	2) Beta Blocker 80% of the time		State
	3) Diuretic 80% of the time		State
10	**Coronary Artery Disease**	Increased utilization of disease specific therapies (meet 2 of 4).	
	1) Cholesterol testing 1X per year		HEDIS®
	2) Statin Therapy 80% of the time		State
	3) ACE/ARB 80% of the time		State
	4) Beta Blocker Post MI for 6 months following MI		HEDIS®
11	**Chronic Obstructive Pulmonary Disease**	Increased utilization of disease specific therapies (meet 2 of 3).	
	1) Acute COPD Exacerbation w/corticosteroid		HEDIS®
	2) History of hospitalizations for COPD with a bronchiodilator medications		HEDIS®
	3) Spirometry testing (1 time in last three years)		HEDIS®

#	Category	Quality Measure	Specification Source
12	**Ambulatory Care**	Emergency Department visits per 1,000 Enrollees	HEDIS®
	1) Waiver Program Support	Services for Population in DD Waiver and Clients with Diagnostic History - Emergency Department Utilization Rate per 1,000	HEDIS®
13	**Ambulatory Care follow-up after Emergency Department Visit**	Follow-up with any Provider within 14 days following Emergency Department visit	State
14	**Inpatient Utilization-General Hospital/ Acute Care**	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS®
15	**Mental Health Utilization**	Mental Health services utilization per 1,0000 Enrollees	HEDIS®
16	**Ambulatory Care Follow-up after Inpatient Discharge**	Ambulatory care follow-up visit within 14 days of every inpatient discharge	State
17	**Inpatient Hospital Re-Admission**	Inpatient Hospital 30 day readmissions. In addition, Mental Health readmissions reported separately	State
18	**Long Term Care Residents – Urinary Tract Infection Hospital Admission**	Hospital Admissions due to urinary tract infections for LTC Residents	AHRQ
19	**Long Term Care Residents – Bacterial Pneumonia Hospital Readmission**	Hospital Admission due to bacterial pneumonia for LTC Residents	HSAG
20	**Long Term Care Residents – Prevalence of Pressure Ulcers**	LTC Residents that have category/ stage II or greater pressure ulcers.	State
21	**Medication Reviews**	Annual monitoring for Enrollees on persistent medications	HEDIS®
22	**Medication Reviews**	Antidepressant Medication Management - At least 84 days continuous treatment with antidepressant medication during 114 day period following Index Episode Start Date (IESD)	HEDIS®
23	**Medication Reviews**	Antidepressant Medication Management - At least 180 days continuous treatment with antidepressant medication during 231 day period following IESD	HEDIS®

#	Category	Quality Measure	Specification Source
24	**Medication Reviews**	Percentage of Enrollees diagnosed with schizophrenia who maintain medication adherence at 6 months and 12 months	State
25	**Preventive Services**	Colorectal Cancer Screening	HEDIS®
26	**Preventive Services**	Breast Cancer Screening	HEDIS®
27	**Preventive Services**	Cervical Cancer Screening	HEDIS®
28	**Preventive Services**	Adult BMI Assessment	HEDIS®
29	**Access to Enrollee's Assigned PCP**	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP.	State
30	**Retention Rate for LTC and HCBS Waiver Enrollees Service in the Community**	LTC and HCBS Waiver Enrollees served in the community at the beginning of the year and continued to be served in the community during the year.	State

Attachment B[12]:
Medicaid Services

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Annual adult (over age twenty (20)) dental cleaning;
- Audiology services;
- Chiropractic services;
- Dental services, including oral surgeons;
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services;
- Hospital ambulatory services;
- Laboratory and x-ray services;
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
- Nursing Facility services;
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services;
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services;
- Post-Stabilization Services;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
- Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090; and
- Transportation to secure Covered Services.

[12] Attachment B lists all Medicaid State Plan services. For dual eligible beneficiaries, Medicare is the primary payer for many of the services.

Attachment C: Home and Community-Based Services

Service	DoA	DHS-DRS			DHS-DDD	Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Adults with DD*			
Adult Day Service	x	x	x	x	x	Adult day service is the direct care and supervision of adults aged 60 and over in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting. The DD version of adult day service also includes transportation.	**DOA:** 89 Il.Adm.Code 240.1505-1590 Contract with Department on Aging, Contract requirements, **DD:** 59 Il.Adm.Code 120.70 Contract with Department on Aging, Contract requirements, **DRS:** 89 Il.Adm.Code 686.100	**DOA, DRS** The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limt. This service will not be duplicative of other services in the Waiver. **DD** For participants who chose home-based supports, this service is included in the participant's monthly cost limit. The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs.
Adult Day Service Transportation	x	x	x	x			**DOA:** 89 Il.Adm.Code 240.1505-1590 **DRS:** 89 Il.Adm.Code 686.100	No more than two units of transportation shall be provided per MFP participant in a 24 hour period, and shall not include trips to a physician, shopping, or other miscellaneous trips.
Case Management (Administrative Claim)	x	x	x	x	x	Case management includes services that assist participants in gaining access to needed MFP, waiver and state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assessment, care plan development and ongoing monitoring and review.	**DOA:** 89 Il.Adm.Code 240.1430 89 Il.Adm.Code 220.605 **DD:** Community-based agencies - Entity under contract with the Operating Agency that provides Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional. 59 Il.Adm.Code 120.70 **DRS:** Required to have at least a GED or CNA as well as experience in working with individuals with disabilities, independent living services, and home care, and a background in the medical aspects of disabilities.	

DoA:Department on Aging
DHS-DRS: Department of Human Services-Division of Rehabilitation Services
DHS-DDD: Department of Human Services-Division of Developmental Disabilities
*Excluded; the State is exploring a phase-in for these services.

Service	DoA	DHS-DRS			DHS-DDD	Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Adults with DD*			
Service Facilitation					x	Service Facilitation includes services that assist participants in gaining access to needed Waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assisting the participant and/or guardian in convening a support planning team, choosing services and service providers to meet the participant's needs, and ensuring participant health and welfare through ongoing monitoring of the provision of services.	Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional. 59 Il.Adm.Code 120.70	This service will not be duplicative of other services in the Waiver. For example, case management/care coordination services are a component of residential services. This service is included in the participant's monthly cost limit. No specific service maximum. The support plan/Service Agreement must set aside at least two hours per month to allow for routine required administrative activities.
Community Transition Services	x	x				Community transition services are non-recurring set-up expenses for MFP participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to establish a basic household but that do not constitute room and board.	Enrolled vendor approved by the Service Facilitator and the participant/guardian	One-time transition services are viewed mainly to be one-time costs. In the event that the MFP participant should need the services after the twelve (12) month period of Money Follows the Person eligibility, Flexible Senior Spending (FSS) funds are available for the MFP participant's needs. No more than $4,000 maximum may be spent per participant on Community Transition Services without the prior approval of the Community Reintegration Program (CRP) Manager or designee.
Environmental Accessibility Adaptations-Home	x	x	x	x	x	Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the participant.	**DOA and DRS:** 89 Il.Adm.Code 686.608 **DD:** 59 Il.Adm.Code 120.70 Independent contractor -Enrolled vendor approved by the Service Facilitator and participant/ guardian Construction companies-Enrolled vendor approved by the Service Facilitator and participant/ guardian.	**DOA** Requests for Home Modifications in excess of the $3,000 limit will be considered on a case-by-case basis by IDOA. Requests for Assistive technology in excess of the $1,000 limit will be considered on a case-by-case basis by IDOA. **DRS** The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum. +l4 **DD** This service is subject to prior approval by the Operating Agency.

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Environmental Accessibility Adaptations-Vehicle					x	Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the support plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.	59 Il.Adm.Code 120.70	This service will not be duplicative of other services in the waiver. This service requires prior approval by the Operating Agency. The following are specifically excluded: 1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant; 2. Purchase or lease of a vehicle; 3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Supported Employment				x	x	Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the participant to locate a job or develop a job on behalf of the participant, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	**DHS:** 89 Il.Adm.Code 530 **DD:** 59 Il.Adm.Code 120.70	**BI** When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilitiesand will not include payment for the supervisory activities rendered as a normal part of the business setting. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. **DD** For participants who chose home-based supports, this service is included in the participant's monthly cost limit. Services are subject to prior approval.
Home Health Aide		x	x	x		Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable.	**DRS:** Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.
Nursing, Intermittent		x	x	x		Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state. Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. Intermittent nursing waiver services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

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Nursing, Skilled (RN and LPN)		x	x	x	x	Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65 **DD:** Registered Nurse or Licensed Practical Nurse, under supervision by a registered nurse: 225 ILCS 65 68 Il.Adm.Code 1300 59 Il.Adm.Code 120.70	**DRS** The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limt. This service will not be duplicative of other services in the Waiver. **DD** There is a State fiscal year maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse. For participants who chose home-based supports, this service is included in the participant's monthly cost limit.
Occupational Therapy		x	x	x	x	Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs	**DRS:** Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55 **DD:** Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant 225 ILCS 75 68 Il.Adm.Code 1315 59 Il.Adm.Code 120.70	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum **DD** This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency.
Physical Therapy		x	x	x	x	Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55 **DD:** Physical Therapist may directly supervise a certified physical therapist assistant. 225 ILCS 90 68 Il.Adm.Code 1340 59 Il.Adm.Code 120.70	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum **DD** This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency.

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Speech Therapy		x	x	x	x	Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Speech therapy through the waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	**DRS:** Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55 **DD:** Speech/Language Pathologist 225 ILCS 110 68 Il.Adm.Code 1465 59 Il.Adm.Code 120.70	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum **DD** This service is included in the participant's monthly cost limit for home-based supports. Services are subject to prior approval by the Operating Agency.
Habilitation - Residential					x	Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community in the most integrated setting appropriate to the individual's needs. It includes case management, adaptive skill development, assistance with activities of daily living, community inclusion, transporation, adult educational supports, social and lesiure skill development, personal support, protective oversight and supervision, and reduction of maladaptive beheviors through positive supports and other methods. It may also include necessary nursing assessment, direction and monitoring by a registered professional nurse (RN), and support services and assistance by an RN or a licensed practical nurse (LPN) to ensure the participant's health and welfare. These include monitoring of health status, medication monitoring, administration of injections or suctioning, administration and/or oversight of the administration of oral and topical medications as appropriate under Illinois law.	59 Il.Adm.Code 115 (DD Comm. Integrated Living Arrangements CILA) 77 Adm. Code 370 (Community Living Facilities - CLF) 59 Il.Adm.Code 50 (DHS OIG) 59 Il.Adm.Code 120.70 (DD Waiver rule) 59 Il.Adm.Code 116 (Med. Administration) Contract requirements	This service will not be duplicative of other services in the Waiver. Residential Habilitation services are available to participants who request this service, require this intensity of service and meet the priority population criteria for residential services. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement, other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the participant's immediate family. Nursing supports are part-time and limited; 24-hour nursing supports are not available to participants in the Waiver.

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Prevocational Services				x		Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).	89 Il.Adm.Code 530	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.
Habilitation-Day				x	x	**BI** Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. **DD** Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the participant's support plan.	**BI** 59 Il.Adm.Code 119 **DD** Community-Based Agencies: 59 Il.Adm.Code 119 (Developmental Training); 59 Il. Adm. Code 50 (DHS OIG) 59 Il.Adm.Code 120.70 (DD Waiver Rule) Contract requirements Special Recreation Associations 59 Il.Adm.Code 119 59 Il.Adm.Code 50 59 Il.Adm.Code 120 Contract requirements	**BI** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the individual's plan of care. **DD** The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Day Habilitation does not include special education and related services which otherwise are available to the participant through a local education agency or vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.
Placement Maintenance Counseling						This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the participant in the home placement. This service is prescribed by a physician based upon his or her judgment that it is necessary to maintain the child in the home placement.	Licensed Clinical Social Worker 225 ILCS 20 Medicaid Rehabilitation Option 59 Il.Adm.Code 132 Licensed Clinical Psychologist 225 ILCS 15	Services will require prior approval by HFS and will be limited to a maximum of twelve sessions per calendar year.

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Medically Supervised Day Care						This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs.	Licensed Day Care Facility 89 Il.Adm.Code 407 Health Care Center 77 Il.Adm.Code 260	This service cannot exceed more than 12 hours per day, five days per week.
Homemaker	x	x	x	x		Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of MFP participants in their own homes in accordance with the authorized plan of care.	**DOA:** 89 Il.Adm.Code 240 **DRS:** 89 Il. Adm. Code 686.200	**DOA, DRS:** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.
Home Delivered Meals		x	x	x		Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum. This service will be provided as described in the service plan and will not duplicate any other services.
Personal Assistant		x	x	x		Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal care providers must meet state standards for this service. The personal assistant is the employee of the consumer. The state acts as fiscal agent for the consumer.	89 Il. Adm. Code 686.10	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum as determined by the DON score. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider and the service is not otherwise covered.

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Personal Support					x	Personal Support includes:· Teaching adaptive skills, personal assistance in activities of daily living (ADLs), and respite services provided on a short-term basis. Personal Support may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home. The need for Personal Support and the scope of the needed services must be documented in the participant-centered support plan. The amount of Personal Support must be specified in the support plan/Service Agreement.	**Personal Support Worker:** 18+ and is deemed by the participant / guardian to be qualified and competent. If hired on or after July 1, 2007, must have passed criminal background and Health Care Worker Registry (HCWR) checks prior to employment. **Community-Based Agencies and Special Recreation Associations:** The Agency must be under contract with the Operating Agency. Employees must complete training, pass training assessments and be certified. All employees must have passed criminal background and HCWR checks prior to employment. 59 Il.Adm.Code 120.70	Personal Support will not be duplicative of other services in the Waiver. For participants who chose home-based supports, this service is included in the participant's monthly cost limit. For participants still enrolled in school, no Personal Support services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.
Personal Emergency Response System (PERS)	x	x	x	x	x	PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	**DOA:** Standards for Emergency Home Response 89 Il.Adm.Code 240 **DD:** Vendor certified by the Department on Aging to provide this service or approved by the Department of Human Services with a current written rate agreement. **DRS:** 59 Il.Adm.Code 120.70 **DRS:** 89 Il. Adm. Code 686.300	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.
Respite		x	x	x		**DRS** Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.	Adult Day Care 89 Il. Adm.Code 686.100 Home Health Aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home Health Agency: 210 ILCS 55 Homemaker 89 Il.Adm.Code 686.200 PA 89 Il.Adm.Code 686.10	**DRS** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in an individual's home or in an adult day care setting.

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Specialized Medical Equipment and Supplies		x	x	x		Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. All items shall meet applicable standards of manufacture, design and installation.	**DRS:** 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51	**DRS:** Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual.
Assistive Technology					x	Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.	Equipment vendor - Enrolled vendor approved by the Service Facilitator and participant/guardian 59 Il.Adm.Code 120.70	Items reimbursed with Waiver funds do not include any assistive technology furnished by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant. This service is subject to prior approval by the Operating Agency.

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Adaptive Equipment					x	Adaptive equipment, as specified in the plan of care, includes devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living or perceive and interact with the environment in which they live.; It also includes such other durable equipment not available under the State plan that is necessary to address participant functional limitations; and necessary initial training from the vendor to use the adaptive equipment. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.	Equipment vendors - Enrolled vendor approved by the Service Facilitator and participant/guardian 59 Il.Adm.Code 120.70	Items reimbursed with Waiver funds do not include any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct remedial benefit to the participant. This service is subject to prior approval by the Operating Agency.
Supportive Living Facilities	x					An affordable assisted living model administered by the Department of Healthcare and Family Services that offers frail elderly (65 and older) or persons with disabilities (22 and older) housing with services.	89 Il Admin Code 146.215	Frail elderly between the ages of 60 and 64 would not be eligible for SLF residency due to the program's minimum age requirement of 65.
Transportation - Non-Medical					x	Non-Medical Transportation is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the support plan. Transportation services under the Waiver are offered in accordance with the participant's support plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.	Drivers must have appropriate state licenses and proof of insurance 59 Il.Adm.Code 120.70	For participants who choose home-based supports, this service is included in the participant's monthly cost limit. This service will not be duplicative of other waiver services. No more than $500 of the monthly cost limit may be used for non-medical transportation services. Excluded is transportation to and from covered Medicaid State Plan services and transportation to and from day program services.
Behavior Intervention and Treatment					x	Behavior intervention and treatment includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. These services are designed to assist participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. The strategies are a component of the participant-centered support plan and must be approved by the planning team. Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments.	59 Il.Adm.Code 120.70 Behavior Consultant 225 ILCS 15/1 et seq 68 Ill. Adm. Code 1400 Clinical psychologist - Services are supervised by a professional. Services are typically provided by a team of professionals. Masters level - professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board. Bachelor's level - professional who is certified as an Associate Behavior Analyst. Professional who is certified to provide Relationship Development Assessment. Professional with a Bachelor's Degree and who has completed at least 1,500 hours or training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder.	For participants who choose home-based supports, this service is included in the participant's monthly cost limit. There is a State fiscal year maximum of 66 hours.

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Behavior Services (Counseling and Therapy)					x	Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.	59 Il.Adm.Code 120.70 Licensed Psychotherapists - 225 ILCS 15/1 et seq 68 Ill. Adm. Code 1400 225 ILCS 20/1 et seq. 68 Ill. Adm. Code 1470 Clinical Social Work 225 ILCS 55/1 et seq. 68 Ill. Adm. Code 1283 Marriage & Family Ther 225 ILCS 107/1 et seq. Licensed Counselors - All licensure categories for psychotherapists, plus Clinical Social Worker and Counselor 225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375	For participants who choose home-based supports, this service is included in the participant's monthly cost limit. There is a State fiscal year maximum of 60 hours for any combination of psychotherapy and counseling services.
Behavioral Services (M.A. and PH.D)				x		Behavioral services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist customers in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. The services are based on a clinical recommendation and are not covered under the State Plan.
Crisis Services					x	Crisis Services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause. The definition of Crisis Services includes the same activities, requirements and responsibilities as Personal Support. The participant, legal representative, the service provider and the support planning team may set mutually acceptable rates for Crisis Services.	Standards are the same as for Personal Support services. 59 Il.Adm.Code 120.70	Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons. The rates must be specified in the Service Agreements and are subject to review and approval by the Operating Agency on either a targeted or a random sample basis. The service is also subject to prior approval by the Operating Agency. This service will not be duplicative of other services in the Waiver. Crisis Services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. No Crisis Services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

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Service	DoA	DHS-DRS			DHS-DDD	Definition	Standards	Service Limits
	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Adults with DD*			
Training and Counseling for Unpaid Caregivers					x	Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. All training for individuals who provide unpaid support to the participant must be included in the participant's support plan. Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the support plan. Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.	59 Il.Adm.Code 120.70 Clinical Psychologist 225 ILCS 15/1 et seq 68 Il.Adm.Code 1400 Clinical Social Work 225 ILCS 20/1 et seq. 68 Il.Adm.Code 1470 Marriage & Family Ther. 225 ILCS 55/1 et seq. 68 Il.Adm.Code 1283 Counselor 225 ILCS 107/1 et seq. 68 Il.Adm.Code 1375 Specialized Training providers - Training programs, workshops or events deemed qualified by the participant/guardian and approved by the Service Facilitator. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.	This service will not be duplicative of other services in the Waiver. For participants who choose home-based supports, this service is included in the participant's monthly cost limit. This service may not be provided in order to train paid caregivers or school personnel. Caregivers who are compensated for direct services under this Waiver may not receive services under this service title.

DoA:Department on Aging
DHS-DRS: Department of Human Services-Division of Rehabilitation Services
DHS-DDD: Department of Human Services-Division of Developmental Disabilities
*Excluded; the State is exploring a phase-in for these services.